471-000-203 Instructions for Completing Form MC-9-NF, "Authorization for Facility Care"

Use: Form MC-9-NF is used to authorize Medicaid payment for Nursing Facility (including Special Needs), ICF/MR-ID, Swing-bed and Hospice-in-facility care. It may be initiated by the provider, Area Agency on Aging or the physician.

Completion: Form MC-9-NF is completed as follows:

SECTION I: (Completed by the initiator)

Client Name: Enter the first and last name of the client.

Client Medicaid Number: Enter the client's 11-digit Nebraska Medicaid number.

Provider Name: Enter the name of the Billing Provider. If Hospice-in-facility also enter the facility name, i.e. hospice/facility name.

Address: Enter the complete address of the Provider.
Note: This document is designed to fit into a window envelope; the name and address section will become the "mailing label".

Provider NPI: Enter the 10-digit National Provider Identifier (NPI) of the Billing Provider, as reported to Nebraska Medicaid.

Taxonomy: Enter the 10-digit Taxonomy Code of the Billing Provider, as reported to Nebraska Medicaid.

Zip+4: Enter the 9-digit Zip Code of the Billing Provider, as reported to Nebraska Medicaid.

SECTION II: (Completed by DHHS Central Office staff or the Area Agency on Aging staff):
Level: Enter the three-digit care level for this client (completed by DHHS Central Office staff).

Signature/Date: The DHHS Program Specialist/RN or Area on Aging staff signs and enters the date.

SECTION III: (Completed by the physician): Note: All Providers must enter the MD NPI number in the box.

For Special Needs and ICF/MR-ID Providers, attach a current history and physical exam or DM-5 (Physicians Confidential Report) and Medication Administration Record. Physician must sign the Certification of Need for Care and enter the MD NPI number.
For Swing-bed Hospitals: attach documentation of Skilled Care, i.e. Medication Administration Record, Skilled Treatment Record, Therapy Plan of Care, and enter the MD NPI number in the box.

SECTION IV: (Completed by Provider):

Diagnoses Name: Enter the client's diagnoses in the following order:

Block one: Primary
Block Two: Secondary
Block Three: Tertiary is for MR diagnosis only

DX Code: Enter the appropriate and valid ICD diagnosis code for the PRIMARY and SECONDARY diagnosis in block(s) number one and two. If the resident has a MR diagnosis, enter the valid ICD code in block number three. For facilities who are Special Needs Providers, Swing-bed Hospitals, and ICF/MR's the diagnosis must be completed.

SECTION V: (Completed by nursing staff of the facility):

Admission Date: Enter the date the client was admitted to the facility, or if a current facility resident is admitted to hospice, enter the day hospice was elected, or whichever date is later. Note: The admission date is the date the client was admitted for the current admission, regardless of payment source.

Identification Screen: Completed by the Area on Aging or the facility depending on whether the SCO Screen is required. Enter the date (mm/dd/yy) the ID Screen was completed.

Medicare Coverage: Enter the dates (from and to) for which Medicare covered the nursing facility care (first and last Medicare covered day).

Discharge: If the resident has been discharged, enter the discharge date.

Signature: The facility signs and dates.

SECTION VI: (Completed by DHHS Central Office staff):

Eligibility Determination Date: Enter the date on which the client's eligibility was determined, if required.

Medical Effective Date: Enter the date on which the client's Medicaid eligibility begins.

Long Term Care Insurance: Check yes or no. If yes, enter the name of the insurance company and the policy number.

Medicaid Payment Effective Date: Enter the date that Medicaid payment to the provider begins. Note: Do NOT include Medicare coinsurance days.

Waiver Client: check yes or no

Medicare Coverage: check appropriate box(s)

Age 65>: check yes or no

Managed Care client: enter the name of the managed care organization name and dates of coverage.

Distribution: The initiator sends the entire form with any attachments to the DHHS Central Office. DHHS Central Office staff returns a photocopy of the completed MC9NF to the facility.

Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Department of Health and Human Services

Authorization for Facility Care

This authorization is void if client is ineligible

SECTION I

Client Name: _____

Client Medicaid No: —

Facility Name _____

Address _____

_____

Facility NPI

Taxonomy

Zip + 4

SECTION II: CENTRAL OFFICE USE ONLY

From the information below, I certify that this client meets criteria for nursing facility care under the Nebraska Medicaid Program at:

Level **Signature** _____ **Date** _____

SECTION III: PHYSICIAN COMPLETES THIS SECTION

If Form DM-5 was used - check here ☐

CERTIFICATION OF NEED FOR CARE: I certify the above-named client is in need of nursing facility care at the time of admission and that nursing facility services continue to be needed.

M.D. Signature _____ M.D. NPI

(required)

SECTION IV: FACILITY STAFF COMPLETES THIS SECTION

DX Code: 1. 2. 3.

MR Diagnosis Only

Diagnoses: Primary _____ Secondary _____

_____ _____

SECTION V: FACILITY STAFF COMPLETES THIS SECTION

Admission Date

Attachment: _____

_____ Identification Screen

Medicare - coverage (if applicable), from _____ to _____ (last date of Medicare coverage).

Signature _____ Discharge Date

SECTION VI: CENTRAL OFFICE COMPLETES THIS SECTION

Eligibility Determination Date _____ Medical Effective Date _____

Long Term Care Insurance ☐ Yes ☐ No - Long Term Care Insurance Company _____

Policy Number _____ Medicaid Payment Effective Date

Waiver client ☐ Yes ☐ No Medicare coverage ☐ A ☐ B Age 65> ☐ Yes ☐ No

Managed care client - Contractor _____ Dates of coverage _____

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(Previous version 9/10 should be used first)